Negroski Neurology & M.S. Center of Sarasota
Donald Negroski, M.D. Valeriy Sabodash, M.D.
5741 Bee Ridge Road, Suite 530, Sarasota, FL 34233
P:(941) 487-2160 F:(941) 487-2170 www.yourfloridaneuro.com

NEW PATIENT REGISTRATION FORM

Date: _____

Demographics

Patient Name: _____ DOB: _____ SSN: _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other: Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Marital Status: ☐Married ☐Single ☐ Divorced ☐ Widowed Preferred Language: ☐ English ☐ Spanish ☐ Other:

Reason for Visit: _____ Referring Doctor: _____

If applicable, previous neurologist name and last visit date: _____

Contact Information & Permissions

Address: _____ City/State _____ Zip _____

Primary Phone: _____ Secondary Phone: _____ Email: (For patient portal) _____

☐ Check here if you **DO NOT** want us to leave appointment, billing, and/or medical information on your voicemail.

Emergency Contact: _____ Phone #: _____ Relationship _____

I give permission for Negroski Neurology share appointment, billing or medical information with the following persons:

Insurance Information *(Please bring current insurance card to all appointments)*

Primary Insurance Company: _____ Is a Referral Required? Yes / No

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Consent To Treat

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by: Donald Negroski, M.D. or Valeriy Sabodash, M.D.

_____ **Pt Initials**

Physician's Assistant

Our practice provides medical services by utilizing Certified Physician Assistants (PA-C) to assist in providing comprehensive Neurologic care to our patients. Our Physician Assistants are certified nationally, and they are qualified and trained to perform medical services in the State of Florida under the supervision of our physicians. Your physician may schedule or recommend an appointment or services with his Physician Assistant to assist in with timely continuance of your medical care.

BY SIGNING BELOW YOU UNDERSTAND OFFICE APPOINTMENTS, AT THE DISCRETION OF OUR PHYSICIANS, MAY BE SCHEDULED WITH A PHYSICIAN ASSISTANT AND THAT YOU AGREE TO RECEIVE APPOINTMENTS AND SERVICES PROVIDED BY TO YOU BY THE PHYSICIAN ASSISTANT.

Patient / LAR Name	**Patient/ LAR Signature**	**Date**

Assignment of Insurance Benefits

Medicare & Supplemental Insurance

I request that payment of authorized Medicare Benefits be made on my behalf to Negroski Neurology for any services rendered or furnished to me by the physician(s). I authorize any holder of medical information about me to release to the Federal Centers for Medicare and Medicaid (CMS) and its State Agency and any fiscal intermediaries needed to determine these benefits or the benefits payable for related services.

I also request that the payment of Medigap(my medicare supplement) benefits be made on my behalf to Negroski Neurology for any services furnished to me by the physician(s). I authorize any holder of medical information needed to determine these benefits for related services.

I understand that I am responsible for payment of any non-covered service(s), deductible(s), and/or co-payment(s) due.

Commercial Insurance

I request that payment of authorized benefits be made on my behalf to Negroski Neurology for any services provided by the physician(s) of this group. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due.

We require a copy of your INSURANCE CARD(S) AND DRIVER LICENSE AT THE TIME OF YOUR FIRST APPOINTMENT.

Be sure to inform us if your insurance information changes.

**** PLEASE READ THIS PAGE CAREFULLY TO UNDERSTAND YOUR RESPONSIBILITIES AS OUR PATIENT ****

NEGROSKI NEUROLOGY FINANCIAL POLICIES

Patient Financial Responsibility

* Payment is due in full at the time of service for all patients without insurance.
* You understand that your medical services will be billed to your insurance company and that any copays, deductible, and/or coinsurance related to your insurance coverage is expected at the time of service. Many times we collect an estimated amount due at the time of service. Once your claim is processed by your insurance carrier, any additional amounts owed will be billed to you. If the patient's estimated amount due results in an overpaid claim, a refund will be processed once all claims are settled and there is no payment due on any other claim or date of service. Exclusions to this policy include Medicare, except for Medicare replacement plans or managed care plans that have a copay, deductible and/or coinsurance.
* Your insurance coverage is between you and your insurance company. You will need to familiarize yourself with the way your insurance company works and how it will pay for tests or procedures. Careful attention to the specifics of your insurance plan can help you avoid incurring out of pocket expenses for medical treatment. **IT IS YOUR RESPONSIBILITY TO KNOW IF YOU NEED PRE-AUTHORIZATION FOR A PROCEDURE OR TESTING AND WHICH LABORATORY IS REQUIRED. IT IS YOUR RESPONSIBILITY TO KNOW WHETHER A REFERRAL or AUTHORIZATION IS REQUIRED TO BE SEEN AT OUR OFFICE. IF A REFERRAL or AUTHORIZATION IS REQUIRED, YOU WILL NEED TO CONTACT YOUR PCP AND HAVE THEM FAX THE AUTHORIZATION DIRECTLY TO OUR OFFICE BEFORE AN APPOINTMENT CAN BE MADE.**
* Negroski Neurology is not responsible for any out-of-pocket expenses that you may incur in relation to any medications, diagnostic testing and/or procedure(s) ordered.
* If your insurance company is not participating, you understand that full payment is expected at the time of service.
* **IF YOUR INSURANCE INFORMATION CHANGES, WE NEED TO KNOW AS SOON AS POSSIBLE.** If we do not have accurate insurance information, medication refills will be delayed and we may be required to reschedule your appointment until accurate insurance information is obtained.
* I understand that failure to comply with the above stated requirements will likely result in delay of care, medications and procedures. It may also result in collection activities regarding my account.

Completion of Forms

There is a charge for completion of forms requiring the physician signature. **VISIT OUR WEBSITE AT YOURFLORIDANEURO.COM TO COMPLETE THE FORM COMPLETION REQUEST AND SUBMIT ALONG WITH THE FORM YOU WANT US TO COMPLETE.** These fees are not payable by insurance and therefore, it is the responsibility of the patient. Payment is required in advance of completion of form. We cannot complete any paperwork on the same day it was submitted, allow a minimum of 7 days for completion.

Complicated/Forms Requiring Narrative….. $50+ Simple Letters/Forms ….. $25

Missed Appointment Fee

We value the doctor/patient relationship, which we believe is built on mutual trust and respect. It is important you realize the physicians time is valuable and inform us if you are not able to attend your appointment so it may be used for another patient.

ANY CANCELLATION MADE LESS THAN 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME OR NOT SHOWING UP FOR YOUR SCHEDULED VISIT IS CONSIDERED A MISSED APPOINTMENT AND MUST BE PAID PRIOR TO RESCHEDULING YOUR APPOINTMENT.

New Patient Appointment No Show / Cancellation < 24 hours …. $75.00
EMG/NCS/EEG No Show / Cancellation <24 hours … $75.00
Follow Up Appointment No Show/ Cancellation <24 hours …. $25.00

We understand that there may be times of unforeseen emergencies and may not be able to keep your appointment. If you experience an extenuating circumstance, you may contact the office manager, who can, at their discretion waive the no-show fee.

By signing below, I have read and understand the terms of this document. I acknowledge, consent and agree to the terms and conditions of this document.

Patient / LAR Name	Patient/LAR Signature	Date

NEW PATIENT REGISTRATION FORM

MEDICAL HISTORY

Please List All Medications You Are Currently Taking or Bring Medication List:

Medication Name	Strength	Frequency	Date Started	Medication Name	Strength	Frequency	Date Started

Known Allergies? If Yes, write name of allergy and reaction(s): _____

Review of Systems: (check any that you have recently experienced)

Systemic	GI	Cardiovascular	Hematological	ENT
☐ Fatigue	☐ Loss of appetite	☐ Chest pain	☐ Easy bruising	☐ Earache
☐ Fever	☐ Trouble swallowing	☐ Fast heart rate	☐ Easy bleeding	☐Hearing Loss
☐ Chills	☐ Heartburn/abdominal pain	☐ Palpitations	**Skin**	☐ Ringing in ears
☐ Weight Change	☐ Nausea/Vomiting	**Pulmonary**	☐ Itching	☐ Nose bleeds
Musculoskeletal	**GU**	☐ Shortness of breath	☐ Rash	☐ Nasal discharge
☐ Joint Pain	☐ Urinary frequency	☐ Cough	**Endocrine**	☐ Throat Pain
☐ Back Pain	☐ Incontinence	☐ Wheezing	☐ Excess sweating	**Eye**
☐ Muscle aches	☐ Kidney Stones	**Psychological**	☐ Excess Thirst	☐ Flashing Lights
☐ Pain in hands and feet	☐ Hesitancy	☐ Anxiety	☐ Change in libido	☐Light sensitivity
Head	**Neck**	☐ Depression		☐ Eye Pain
☐ Headache	☐ Neck Pain	☐ Insomnia		☐ Double Vision
☐ Facial/Sinus Pain	☐ Neck Stiffness			☐ Blurry Vision

Your Medical History (check each box that applies)

☐ Migraine Headache	☐ Coronary artery disease	☐ Thyroid disease	☐ Polio
☐ Tension Headache	☐ Congestive heart failure	☐ Liver disease	☐ Rheumatic fever
☐ Epilepsy/Seizures	☐ Arrhythmias	☐ Hepatitis	☐ Allergy/Hay fever
☐ Stroke	☐ Heart murmur	☐ Renal/kidney disease	☐ Current smoker _____ per day
☐ Head injury	☐ Hypertension	☐ Digestive/bowel problems	☐ Quit smoking _____ago
☐ Neuromuscular problems	☐ Peripheral vascular disease	☐ Gastric ulcer	☐ Currently drink _____ per day
☐ Spinal cord injury	☐ Anemia	☐ Arthritis	☐ Quit drinking _____ago
☐ Cervical spine disease	☐ Bleeding disorder	☐ Cancer	☐ Depression/Anxiety
☐ Lumbar spine disease	☐ COPD	☐ TB	☐ Genitourinary disease
☐ Peripheral neuropathy	☐ Pneumonia	☐ HIV	☐ Venereal disease
☐ CNS malignancy	☐ Diabetes	☐ Mumps	☐ Menstrual problems
☐ Heart attack/MI	☐ Endocrine problems	☐ Measles	☐ Sexual dysfunction

Preferred Pharmacy

Name		Phone	
Address		Fax	
		Zip	

Surgical History

☐ No Prior Surgeries

No	Yes	Type	Date	Reason
☐	☐	Head:		
☐	☐	Neck:		
☐	☐	Back:		
☐	☐	Other:		

Family Medical History

	Father	Mother
Heart disease	Y | N	Y | N
Cancer	Y | N	Y | N
Epilepsy	Y | N	Y | N
Stroke	Y | N	Y | N
Parkinson's Disease	Y | N	Y | N
Migraines	Y | N	Y | N
Mental illness	Y | N	Y | N
Dementia	Y | N	Y | N
Alive (at age)		
Deceased (at age)		